Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

cc. 6/3/08 ✓
To: Neville -
From: Betsy
FYI
Original to file

May 22, 2008

Ms. Elizabeth A. Johnson
Commissioner
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40621-0001

Attention: Kevin Skeeters

RE: Kentucky Title XIX State Plan Amendment, Transmittal #06-005

Dear Ms. Johnson:

We have reviewed the proposed amendment to the Kentucky Medicaid State Plan received under transmittal number 06-005 on March 31, 2006. This plan amendment changes the university physician supplemental payment methodology from actual and customary rates to a commercial average. In order to be eligible for a supplemental payment, the physician/dentist must be licensed in Kentucky, be enrolled as a Kentucky Medicaid provider, be a Medical School Faculty Physician or Dental School Faculty Dentist (as defined) with an agreement to assign their payments to the State-owned academic medical centers in accordance with 42 CFR 447.10.

Under regulations at 42 CFR 430.12 (c)(i), States are required to amend State Plans whenever necessary to implement changes in Federal Law, regulations, policy interpretations, or court decisions. On May 25, 2007, CMS placed a final rule, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial partnership) on display at the Federal Register that can be found at 72 Fed. Reg. 29748 (May 29, 2007), that would modify Medicaid reimbursement. Because of this regulation, some or all of the payments under this plan amendment may no longer be allowable expenditures for Federal Medicaid matching funds. Public Law 110-28, enacted on May 25, 2007, instructed CMS to take no action to implement this final regulation for one year. CMS will abide by the time frames specified by the statute. Approval of the subject State Plan amendment does not relieve the State of its responsibility to comply with changes in Federal laws and regulations and to ensure that claims for Federal funding are consistent with all applicable requirements.

Ms Elizabeth A. Johnson
RE: Kentucky Title XIX State Plan Amendment, Transmittal #06-005

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 06-005 was approved on May 15, 2008. The effective date for this amendment is January 01, 2006. We are also enclosing the approved HCFA-179 and plan pages.

If you have any questions or need any further assistance, please contact Maria Donatto at 404-562-3697 or Yvette Moore at (404) 562-7327.

Sincerely,

Teresa DeCaro, RN, M.S.
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 06-005

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2006

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC 1396b(w)

7. FEDERAL BUDGET IMPACT:
Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B Page 20.5-20.6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:

Provider Tax Supplement Payments

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Shannon Turner, J.D.

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED:

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/31/06

18. DATE APPROVED: 05/15/08

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/06

20. SIGNATURE OF REGIONAL OFFICIAL: 05/22/08

21. TYPED NAME: Teresa DeCaro

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

Approved with the following changes as authorized by the State Agency email dated on May 19, 2008:

Block 7: Change to read Block 7: FFY06 = save ($18,900,000)
Change to read FFY07 = save ($18,900,000)

Block 8: Add Atch 4.19-B, pages 20.3 and 20.7

Block 9: Atch 4.19-B, Page 20.08 (remove from State Plan)

)RM HCFA-179 (07-92)

II. Physician Services

A. Definitions

(1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.

(2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.

(3) "Medical School Faculty Physician" is a physician who is employed by a state-supported school of medicine (for teaching and clinical responsibilities), receives their earnings statement (W-2) from the state-supported school of medicine for their teaching and clinical responsibilities, and they are part of a university health care system that includes:

(a) a teaching hospital; and
(b) a state-owned pediatric teaching hospital; or
(c) an affiliation agreement with a pediatric teaching hospital.

B. Reimbursement

(1) Payment for covered physicians' services shall be based on the physicians' usual and customary actual billed charges up to the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS).

(2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

(8) Payments for the injection procedure for chemonucleolysis of invertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or at a fixed upper limit of *$793.50* as established by the Department.

(9) Specified family planning procedures performed in the physician office setting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS *fee* plus actual cost of the supply minus ten percent.

(10) Certain injectable anitbiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.

(11) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).

(12) For a practice-related service provided by a physician assistant, the participating physician shall be reimbursed at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the Department for Medicaid Services at seventy-five (75) percent of the physician's fixed upper limit per procedure.

(13) Any physician participating in the lock-in program will be paid a $10.00 per month lock-in fee for provision of patient management services for each recipient locked-in to that physician.

(14) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan to physicians that qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.

a. To qualify for a supplemental payment under this section, physicians must meet the following criteria:
   1. Be Kentucky licensed physicians;
   2. Be enrolled as Kentucky Medicaid providers; and
   3. Be Medical School Faculty Physicians as defined in Att 4.19-B, page 20.3, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.

b. For physicians qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between payments otherwise made to these physicians and the average rate paid for the services by commercial insurers. The payment amounts are determined by:
   1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the providers' contracted rates with commercial insurers for each procedure code from an actual year's data, beginning with CY 2006;
   2. Multiplying the total number of Medicaid claims paid per procedure code by the average commercial payment rate for each procedure code to establish the estimated commercial payments to be made for these services; and
   3. Subtracting the initial fee-for-service Medicaid payments, all Medicare payments, and all Third Party Liability payments already made for these services to establish the supplemental payment amount. Effective January 1, 2007 all claims where Medicare is the primary provider will be excluded from the supplemental payment methodology.
   4. The supplemental payments will be calculated annually after the end of each CY using actual data from the most recent completed CY. Claims data will only be used for physicians meeting the criteria in Part (a) above. If a physician did not meet the criteria for the whole calendar year, then only the claims data that coincides with their dates of eligibility will be used in the calculation. The supplemental payments will not be increased with any trending or inflationary indexes.

c. Initial fee-for-service payments under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made as four (4) equal quarterly payments.

D. Assurances. The State hereby assures that payment for physician services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.

III. Dental Services

A. Definitions

(1) For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

(2) "Dental School Faculty Dentist" is a dentist who is employed by a state-supported school of dentistry (for teaching and clinical responsibilities) and who receives their earnings statement (W-2) from the state-supported school of dentistry for their teaching and clinical responsibilities.

B. Reimbursement for Outpatient and Inpatient Services

(1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist's actual billed charge not to exceed the fixed upper limit per procedure established by the department.

(2) With the exceptions specified in section (3), (4), and (5), the upper payment limit per procedure shall be established by increasing the limit in effect on 6/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states based upon a survey of Dental Fees by the American Dental Association.

(3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper limit by the following:

a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen's Compensation, private insurers or three (3) high volume Medicaid providers:
b. An average limit based upon these rates will be calculated; and
c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.

(4) The following reimbursement shall apply:

a. Orthodontic Consultation, $112.00, except that a fixed fee of $56.00 shall be paid if:
   1. The provider is referring a recipient to a medical specialist;
   2. The prior authorization for orthodontic services is not approved; or
   3. A request for prior authorization for orthodontic services is not made.
b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, $1,367 for orthodontists and $1,234 for general dentists.
c. Prior authorized orthodontic services for moderately severe disabling malocclusions, *$1,825* for orthodontists and $1,649 for general dentists.
d. Prior authorized orthodontic services for severe disabling malocclusions, $2,754 for orthodontists and $2,455 for general dentists.
e. Prior authorized services for Temporomandibular Joint (TMJ) therapy, an assessed rate per service not to exceed $424.

(5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.

(6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:

a. The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and

b. In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

(7) Supplemental payments will be made for services provided by dental school faculty dentists either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan dentists that qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.

a. To qualify for a supplemental payment under this section, dentists must meet the following criteria:

1. Be Kentucky licensed dentists;
2. Be enrolled as Kentucky Medicaid providers; and
3. Be Dental School Faculty Dentists as defined in Att 4.19-B, page 20.6, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.

b. For dentists qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between payments otherwise made to these dentists and the average rate paid for the services by commercial insurers. The payment amounts are determined by:

1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the providers' contracted rates with commercial insurers for each procedure code from an actual year's data, beginning with CY 2006;
2. Multiplying the total number of Medicaid claims paid per procedure code by the average commercial payment rate for each procedure code to establish the estimated commercial payments to be made for these services; and
3. Subtracting the initial fee-for-service Medicaid payments, all Medicare payments, and all Third Party Liability payments already made for these services to establish the supplemental payment amount. Effective January 1, 2007 all claims where Medicare is the primary provider will be excluded from the supplemental payment methodology.
4. The supplemental payments will be calculated annually after the end of each CY using actual data from the most recent completed CY. Claims data will only be used for dentists meeting the criteria in Part (a) above. If a dentist did not meet the criteria for the whole calendar year, then only the claims data that coincides with their dates of eligibility will be used in the calculation. The supplemental payments will not be increased with any trending or inflationary indexes.

c. Initial fee-for-service payments under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made as four (4) equal quarterly payments.

C. Assurances. The State hereby assures that payment for dentists services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.